

RtI STRATEGIES

General Health Screening

Tier 2

Date Completed: _____
Completed by: _____
Position: _____

Student Name: _____ District/Campus: _____

SSN#: _____ Grade: _____ Classroom Teacher: _____

HEALTH

Y N Does the student exhibit any signs of health or medical problems?
If yes, explain: _____

Y N Is there a need for further assessment or referral of a medical problem?
If yes, explain: _____

Y N Does this student require adaptive equipment?
If yes, explain: _____

VISION

Does the student wear glasses? **Y N** Does the student wear contacts: **Y N**

Please list type of screening used: _____

Right Eye: pass fail Left Eye: pass fail

Y N Is there an indication or need for further assessment?

Y N Has any follow up treatment been recommended?

HEARING

Please list type of screening used: _____

Right Ear: **PASS/FAIL** Left ear: **PASS/FAIL**

Y N Is there any indication or need for further assessment?

Y N Has any follow up treatment been recommended?

Signature of person conducting screening

Printed Name